STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey with a PSR for the Quality Assurance Walk-thru Survey conducted on 10/31/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/12/13 Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Covington Manor Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of the West wing, East wing, Bed and Breakfast unit and the service hall was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to	K010000	K0000: *This Plan of Correction is the center's credible allegation of compliance. *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors with battery operated smoke detector in the resident rooms. The facility has a capacity of 149 and had a census of 116 at the time of this survey. The facility was found in compliance with state law in regard to smoke detector coverage and sprinkler coverage. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/18/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 1 resident in the Bed and Breakfast unit. Findings include: Based on an observation with the Maintenance Director on 03/12/13 at 11:38 a.m., there is a one and one half inch hole in the ceiling next to the sprinkler head in the closet of resident room 401 in the Bed and Breakfast unit. The measurement was provided by the Maintenance Director at the time of observation. 3.1-19(b)	K010025	K0025: *The facility will ensure ceiling smoke barriers are maintained to provide a one half hour fire resistant rating. *Other residents have the potential to be affected. The hole in the closet of room 401 has been repaired to comply with regulation. *Maintenance staff has completed a thorough review of all areas in the facility to ensure there are no additional similar areas out of compliance. Maintenance will add this visual check and follow up to their monthly building review for compliance. * Results of monthly checks will be brought to the facility monthly QA&A committee for review and follow up for a minimum of 6 months and until the facilitiy sustains a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 10 exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient practice could affect any residents evacuated through the service hall from the main dining room in the event of an emergency. The main dining room had chairs to seat 26 residents. Findings include: Based on observation with the Maintenance Director and the Director of Environmental Services on 03/12/13 at 12:46 p.m., the door entering the service hall, which was equipped with electromagnetic locks, failed to release when applying force to the door for twenty four seconds. When tested by the Maintenance Director at the time of observations, he acknowledged the door failed to release after twenty four seconds. 3.1-19(b)	K010038	K038: *The facility will continue to ensure exit doors are accessible. *The facility's security company has reset the door to the service hall to comply with 15 second release requirement. *The door is a entry way to the facility's service hall where all deliveries are received and is not typically used for evacuation. Should the dining room have to be evacuated in an emergency an exit door in the dining room could be used in that instance. Maintenance staff will monitor the release on the door daily 5x/week for 2 weeks, 1x/weel for 2 weeks then monthly going forward to ensure compliance. *Results of monitoring will be brought to the facility QA&A committee monthly for a minimum of 6 months and until the facility has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 Based on observation and interview, the facility failed to ensure 1 of 10 exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect any residents evacuated through the service hall from the main dining room in the event of an emergency. The main dining room had chairs to seat 26 residents. Findings include: Based on an observation with the Maintenance Director and the Director of Environmental Services on 03/12/13 at 12:50 p.m., there were cardboard boxes stacked in the service hall. At least seven of the cardboard boxes were stored so the width of the corridor measured thirty eight inches. Measurements were provided by the Maintenance Director at the time of observation. The Maintenance Director and the Director of Environmental Services confirmed the service hall was used as an emergency exit at the time of observations. 3.1-19(b)	K010039	K039: *Exit access corridors will have a clear and unobstructed exit width of at least 48 in. *The cardboard boxes were removed from the service hall. This corridor is used for delivery of supplies. In case of a need for evacuation of residents in the dining room the exit door in the dining room could be used. *Maintenance and environmental services staff will promptly distribute supplies upon delivery. The Administrator will monitor daily 5x/week for 1 month to ensure compliance. *Results of daily monitoring will be brought to the monthly QA&A committee for review and follow up for a minimum of 6 months and until the facility has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Report" with the Maintenance Director on 03/12/13 at 1:15 p.m., there was no record of a third shift fire drill for the third quarter of 2012. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b) 3.1-51(c)	K010050	K050: *The faciity will ensure fire drills are conducted quarterly on all three shifts. *All residents have the potential to be affected. The maintenance staff will conduct fire drills ensuring a drill on each shift is done each quarter. *The Administrator will review fire drills monthly going forward to ensure compliance. *Results of monthly monitoring will be brought to the facility monthly QA&A committee for review and follow up for a minimum of 6 months and until the faciltiy has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice was not in a resident care area but could affect kitchen staff in the event of an emergency. Findings include: Based on record review with Maintenance Director on 03/12/13 at 1:34 p.m., the Koorsen Fire and Security inspection form indicated "Regulator testing needed to be performed. No label or sticker stating that this service was performed." Based on interview with the Maintenance Director at the time of record review, he was unable to provide documentation to confirm the regulator had been tested. 3.1-19(b)	K010069	K069: *The facility will ensure testing of the regulator is completed per regulation. *The regulator has been tested and is in compliance with regulation. *Maintenance staff has been reminded to fully review inspection reports and promptly follow up on areas noted as not completed during the inspection. Maintenance will forward to the Administrator copies of all inspections to ensure prompt follow up on areas noted as not completed during the initial inspection. *Inspections not fully completed at time of initial inspection will be forwarded to the monthly QA&A committee for a review and follow up for a minimum of 6 months and until the faciltiy has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on observation and interview, the facility fail to ensure 1 of 1 east hall duct penetrations was provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affect all 22 resident on east hall. Findings include: Based on observations with the Maintenance Director on 03/12/13 at 2:44 p.m., a smoke damper was not installed in the ventilation duct which penetrated the attic smoke barrier wall on the south hall near resident room 307. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)	K010104	K104: *The facility will ensure hall duct penetrations be provided with a smoke damper. *All residents have the potential to be affected. The facility contacted a contractor to install the smoke damper and it was determined by the contractor a smoke damper was already present in the ventilation duct near room 307 and was present at the time of this survey. see attached *Maintenance staff will ensure all dampers are included on the list of dampers and will be inspected every 4 years to ensure compliance. *Maintenance staff will monitor every 4 year inspection of dampers to ensure all dampers are inspected to ensure compliance.	03/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect staff. Findings include: Based on an observation with the Maintenance Director on 03/12/13 at 11:18 a.m., a heavy duty extension cord was plugged in and providing power to a desk top computer in the Director of Staff Development's office. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)	K010147	K147: *The facility will ensure flexible cords such as extension cords not be used as a substitute for fixed wiring. *The extension cord was removed. Staff have been reminded not to bring extension cords into the facility. *The maintenance staff will monitor all areas of the facility monthly to ensure compliance. The administrator will visually check all non resident areas at a minimum of 1x/month to ensure compliance. *The results of monitoring will be brought to the monthly QA&A committee for review and follow up for a minimum of 6 months and until the facility has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K020000	A Life Safety Code Recertification and State Licensure Survey with a PSR for the Quality Assurance Walk-thru Survey conducted on 10/31/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/12/13 Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Covington Manor Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The new section of the building consisting of the Rehabilitation wing was surveyed with Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was	K020000	K0000: *This Plan of Correction is the center's credible allegation of compliance. *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 02 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors with battery operated smoke detector in the resident rooms. The facility has a capacity of 149 and had a census of 116 at the time of this survey. The facility was found in compliance with state law in regard to smoke detector coverage and sprinkler coverage. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 02 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K020050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Report" with the Maintenance Director on 03/12/13 at 1:15 p.m., there was no record of a third shift fire drill for the third quarter of 2012. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b) 3.1-51(c)	K020050	K050: *The faciity will ensure fire drills are conducted quarterly on all three shifts. *All residents have the potential to be affected. The maintenance staff will conduct fire drills ensuring a drill on each shift is done each quarter. *The Administrator will review fire drills monthly going forward to ensure compliance. *Results of monthly monitoring will be brought to the facility monthly QA&A committee for review and follow up for a minimum of 6 months and until the faciltiy has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2013